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CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

Client factors that predict the therapeutic alliance in a chronic, complex trauma sample

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Abstract

This investigation aimed to examine how specific client characteristics of individuals with chronic, complex trauma are associated with the type coping strategies they employ and the quality of the therapeutic alliance. Fifty-nine adult participants with diagnostic levels of posttraumatic stress disorder (PTSD) and who attended therapy for complex trauma in Northern Ireland were obtained via opportunity sampling. Participants completed self-report measures of client attachment style, alexithymia, coping strategies, and the therapeutic alliance. Preoccupied attachment factors such as “Need for Approval” and “Preoccupation with Relationships” were related to use of maladaptive coping strategies. In contrast, the adaptive coping strategies of “Acceptance” and “Instrumental Support” were significant predictors of a positive therapeutic alliance, whereas established psychological and traumatogenic factors (e.g., attachment, number of traumatic events) did not significantly predict the therapeutic alliance. The findings have implications for understanding the relationship between client characteristics and the therapeutic alliance within complex trauma populations, as well as developing protocols to assist this process.

Keywords: Therapeutic Alliance, complex trauma, client factors, coping

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

Client characteristics, coping strategies, and the therapeutic alliance in a chronic, complex trauma sample

Defined broadly as the collaborative and affective bond between therapist and client, the therapeutic alliance has long been considered an essential element of the therapeutic process. Research has consistently found a substantive relationship between the alliance and therapeutic effectiveness, regardless of therapeutic orientation, presenting problem, or problem severity (Goldsmith, Lewis, Dunn, & Bentall, 2015; Martin, Garske, & Davis, 2000). The capacity to engage in an effective therapeutic alliance, however, is thought to require concomitant implementation of certain coping strategies by clients (e.g., reflection, active coping, openness), which can prove challenging (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998).

One clinical group in which this area of study is particularly relevant is individuals who have experienced chronic, complex or childhood trauma. Herman (1992) proposed the concept of ‘Complex PTSD’, or ‘Complex Trauma’ as it is also known, to describe the multifaceted clinical presentation of individuals experiencing protracted, recurring trauma, particularly of an interpersonal nature (e.g., childhood sexual abuse, sectarian violence). Compared to clients with a discrete or ‘simple’ PTSD presentation, individuals with complex PTSD have a more severe and comprehensive symptom profile. This includes disturbance to personality, self-identity and ability to develop/maintain interpersonal relationships (e.g., Taylor, Asmundson & Carleton, 2006). De Jong, Komproe, Spinazzola, Van der Kolk and Van Ommeren (2005) argued that the types of traumatic events associated with complex PTSD “... are rampant in situations in which people are exposed to war, genocide, persecution, political repression, torture, ethnic cleansing, terrorism, poverty, and other calamities.” (p. 14). Many of the experiences conducive to developing Complex

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

PTSD/trauma have been experienced over the past 35 years in communities in Northern Ireland as a result of “The Troubles” sectarian conflict (Dorahy et al., 2009; Dyer et al., 2009)

Anecdotal observations suggest that complex trauma populations experience difficulties in developing adaptive coping strategies and forming an open, trusting therapeutic alliance (Pearlman & Courtois, 2005). This is perhaps unsurprising as Complex PTSD/trauma is primarily a relational disorder with antecedents in interpersonal trauma and consequences for interpersonal coping and social connectedness (Dorahy et al., 2009). Early and prolonged trauma across key developmental stages has been repeatedly shown to negatively impact on the ability to regulate emotions using adaptive coping methods and form healthy relationships (Ben-Naim, Hirschberger, Ein-dor, & Mikulincer, 2013). Yet, at the same time, recovery from complex trauma often requires the individual to be in a healing relationship and empowered by that relationship (Herman, 1992). Survivors of complex trauma, therefore, may exhibit personality characteristics, emotional regulation styles and maladaptive coping strategies that are not only harmful to their overall wellbeing, but also prevent later recovery.

The types of coping methods considered unhelpful or maladaptive within the complex trauma literature are varied, but are thought to include avoidance (e.g., safety behaviours, distraction), adverse emotional regulation strategies (e.g., self-harm, alcohol/substance misuse), dissociation, anger/aggression, and primitive defense mechanisms such as denial (Courtois, 2008; Dorahy et al., 2009; Dyer et al., 2009). Adaptive coping refers to use of strategies such as social/instrumental support, effective emotional processing and regulation (e.g., reflection, acceptance, cognitive flexibility), active problem-solving, and mature defense mechanisms (Hassija, Garvert, & Cloitre, 2015; Vaillant, 2011). Maladaptive coping styles have been linked to greater levels of PTSD symptoms in complex trauma populations (Boden et al., 2014; Johnson, Sheahan & Chard, 2003). Moreover, avoidant coping and a reduced therapeutic alliance have been evidenced as significant predictors of post-trauma

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

psychological distress and poorer PTSD treatment outcome (Badour, Blonigan, Boden, Feldner, & Bonn-Miller, 2012; Ormhaug, Jensen, Wentzel-Larsen, & Shirk, 2014).

Despite the above evidence, limited research has examined the specific client characteristics in complex trauma populations that are salient in the development of adaptive coping methods and a positive therapeutic relationship. In general clinical populations, variables such as client motivation, cognitive style, and psychological mindedness have been found to contribute to these processes (Tryon, Blackwell, & Hammel, 2007; Hersoug, Hoglend, Havik, Lippe and Monsen, 2009). Meier, Donmall, Barrowclough, McElduff, and Heller (2005) also reported that adaptiveness of coping strategies at therapy intake prospectively predicted the therapeutic alliance in substance misusers. A greater understanding of such relationships would allow therapists to be more responsive in therapy and flexible in managing alliance ruptures, thus increasing the likelihood of positive therapeutic outcome.

Established PTSD and clinical theoretical models (e.g., Ehlers and Clark, 2000, Herman, 1992) give an indication of the potential client factors that may be relevant. Complex trauma often emerges from aversive childhood experiences that disrupt attachment, which, in turn, affect cognitive-emotional development (e.g., core beliefs, internal working models), and later personality and interactional/coping styles. Potential insecure adult attachment styles that can develop include anxious-preoccupied, dismissive-avoidant, and fearful avoidant styles (Bartholomew & Horowitz, 1991). Severe trauma can alter neurobiological development in children, particularly prefrontal limbic areas and the autonomic nervous system. The specific direction of these maturational deviations often express themselves as different attachment styles, e.g., dismissive-avoidance attachment emerging from unconscious, low affect neurological regulation preferences (Schorer, 2001). From this rationale, attachment pattern, cognitive-emotional factors (e.g., alexithymia), and

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

the dominant behavioural coping strategies of clients could be highly salient factors in the therapeutic alliance of clients with PTSD (Ackerman & Hilsenroth, 2003; Black, Curran, & Dyer, 2013).

The effect of client attachment style on the therapeutic alliance has a strong research base. Clients with secure or “earned secure” attachment who are able to depend on their therapists and feel comfortable with intimacy tend to form stronger alliances (Kivlighan, Patton, & Foote, 1998; Pearson, Cohn, Cowan, & Cowan, 1994; Satterfield & Lyddon, 1995). Although, interestingly, it has also been found that attachment style, particularly client avoidance or anxiety has no effect upon therapeutic alliance (Sauer, Lopez & Gormley, 2003; Reis & Grenyer, 2004). Moreover, to date, no published attachment-based research has focused solely on the clinical population of PTSD (Smith & Golding, 2010).

Complex trauma and attachment difficulties can have a substantial impact upon emotional intelligence. Alexithymia represents a notable deficit in affective coping resources that may also have a detrimental effect on the formation of a therapeutic alliance. Individuals with alexithymia exhibit difficulties in identifying/distinguishing feelings and bodily sensations, as well as problems in labeling and communicating emotional experiences (Paivio & McCulloch, 2004). Alexithymia has been found to develop as a result of early trauma, particularly abuse and neglect experiences during periods of emotional development. Such experiences impair the capacity for both self-regulation of affective states and the ability to utilize interpersonal relations for affect management (Hund & Espelage, 2006, Polusny, Dickinson, Murdoch & Thuras, 2008). There is limited research on the role of alexithymia in the therapeutic relationship, particularly for individuals with complex trauma. Holvey (1996) examined the relationship between alexithymia and therapeutic alliance in a sample of heterogeneous mental health presentations. A significant negative relationship between

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

difficulty identifying and exploring feelings and the therapeutic alliance was found during the initial session; however, this association reduced to non-significance in later sessions.

In the same way deficits in emotional coping such as alexithymia have received limited empirical attention in relation to the alliance, there is also little known about how generic client coping strategies directly impact on the relationship. This dearth of research is surprising considering the aforementioned clinical theoretical links between trauma, coping and relationships. Many of the symptoms of complex trauma reflect global problems in “coping” due to repeated traumatisation. Therefore, the probability of such individuals engaging in instinctive, maladaptive coping strategies (e.g., social withdrawal, dissociation; Dorahy et al., 2009) is high and could impede alliance development.

The previous review illustrates that the therapeutic alliance is a central part of psychotherapy and there is a need to further understand the various factors that affect alliance formation, particularly in chronic, complex trauma populations. The aim of this study, therefore, was to examine the association between specific client characteristics and both the type of coping strategies employed and the quality of therapeutic alliance of individuals receiving psychotherapy for complex trauma. Specifically, it was hypothesized that 1) client psychological factors of insecure attachment and alexithymia would significantly predict levels of adaptive and maladaptive coping strategies used by individuals with chronic, complex trauma; and 2) insecure attachment, alexithymia, and coping strategies used by individuals with chronic complex trauma would significantly predict quality of the therapeutic alliance.

Method

Participants

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

Participants were sampled from two clinical settings. The first was an urban complex trauma service treating adults with psychological difficulties and multiple traumas related to “The Troubles” conflict. The second setting was an urban adult mental health service treating chronic, severe trauma reactions. All 126 clients attending therapy in the two services were approached to take part in the research.

Study inclusion criteria were; 1) aged eighteen or above; 2) a history of multiple traumatic experiences as acknowledged on the Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox & Perry, 1995), for which they were receiving treatment; 3) a clinician-assessed diagnosis of PTSD, either using the PDS or DSM-IV criteria (American Psychiatric Association [APA], 1994); 4) attending psychotherapy for a minimum of three sessions. Participants were excluded from the study if they were 1) actively suicidal; 2) had a diagnosis of a learning disability; 2) had a diagnosis of a degenerative neurological disorder. Information derived from using the PDS and other PTSD assessment data was not available to the researchers for analysis within this study due to ethics approval limitations on accessing historical clinical information

Fifty-nine clients volunteered to take part in the study, and all participants met inclusion/exclusion criteria. Thirteen participants (22%) were female and forty six (78%) were male, ranging in age from 25 to 69 years old ($M = 50.91$, $SD = 8.84$).

All participants were clients of 10 therapists (4 male; 6 female) aged 33 to 60 years old working in the above services. In terms of therapist discipline, two clinical psychologists, three person-centered counselors, three trainee counselors, one physiotherapist and one occupational therapist were involved in the study. The service employed an interdisciplinary model of team working. The physiotherapist and occupational therapist were also clinically trained in psychodynamic psychotherapy and CBT respectively. Consequently, their alliance ratings related to clients who comprised a small additional caseload for which these staff

members provided psychological therapy. The type of therapeutic model experienced by participants depended on their specific needs, but options included trauma counselling, trauma-focused CBT, phase-oriented trauma therapy, psychodynamic psychotherapy, and systemic therapy.

Materials/Apparatus

Toronto Alexithymia Scale – 20 (TAS-20; Bagby, Taylor & Parker, 1994). This 20-item self report instrument contains items rated from 1, strongly disagree to 5, strongly agree. The sum of all 20 items generates a univariate TAS total score. Higher scores correspond with a higher tendency to experience alexithymia. Factor structure coefficients range from 0.62 – 0.88 (Cleland et al., 2005) and evidence of convergent/discriminant validity of the TAS-20 were demonstrated in the original study (Bagby et al., 2005). Both internal reliability and test-retest reliability coefficients (alpha) have been reported as 0.87 (Kooiman, Spinhoven & Trijsburg, 2002). Cronbach's alpha for the total TAS was 0.81 in the present study.

Brief COPE (Carver, 1997). The Brief COPE scale (Carver, 1997) is a 28-item self-report measure of both adaptive and maladaptive coping skills. Each item is measured using a four point Likert scale. The scale has fourteen two-item subscales, namely self-distraction, active coping, denial, substance use, seeking emotional support, seeking instrumental support, behavioural disengagement, venting, positive reframing, planning, humor, acceptance, turning to religion, and self-blame. These subscales can be combined into two superordinate scales representing *adaptive coping* (active coping, seeking emotional support, seeking instrumental support, positive reframing, planning, humor, acceptance, turning to religion) and *maladaptive coping* (self-distraction, denial, substance use, behavioural disengagement, venting, and self-blame). The Brief COPE has demonstrated reasonable

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

content validity (Carver, 1997). Cooper, Katona and Livingston (2008) report good internal consistencies for the subscales ranging from 0.72 – 0.84 and adequate test-retest reliability of 0.58 – 0.72. Internal consistency coefficients for the 14 subscales and two superordinate scales ranged 0.63 – 0.94 in the present study.

Attachment Style Questionnaire (ASQ; Feeney, Noller & Hanrahan, 1994). The ASQ is a 40- item self- report instrument containing five dimensions (Confidence, Pre-occupation with relationships, Need for approval, Relationships as Secondary and Discomfort with closeness) and three categories of attachment style (secure, preoccupied and dismissing categories). The Confidence dimension (8 items) relates to secure attachment behaviours such as trust in others and belief in self worth. Two subscales measure Preoccupied attachment behaviours: 1) Pre-occupation with Relationships (8 items) is described as an anxious reaching out to others in order to fulfil dependency needs; and 2) Need for Approval (7 items) reflects the individuals need for others' acceptance and confirmation. There are also two scales that measure dismissing attachment behaviours: 1) Relationships as Secondary (7 items) contains items which describe the individuals protecting themselves against hurt and vulnerability by emphasizing achievement and independence; and 2) Discomfort with closeness (10 items) relates to feeling uncomfortable with intimacy and closeness. Alpha coefficients for the three categories ranged from 0.83 to 0.85 in the original study (Feeney et al. 1994) and from 0.8 to 0.87 for the five dimensions in the present investigation.

Working Alliance Inventory (WAI; (Horvath & Greenberg, 1986). This is a 36- item client and therapist self-report measure of the three elements of Bordin's (1979) conceptualization of therapeutic alliance (i.e., Goals, Tasks, and Bond). Total possible score is 252, with higher scores indicating a stronger working alliance. The WAI has been

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

repeatedly utilised in the literature as a dependent variable in many research studies (Martin et al., 2000). Reliability and validity of the measure have been supported in multiple investigations (Dunkle & Friedlander, 1996). In the current study, WAI Cronbach's alpha was reported as 0.9.

Clinical factors. Clients provided information on the number and type of traumas they experienced. The types of trauma classified according to categories in the PDS and previous "Troubles"-related screening instruments (Dyer et al., 2009; Foa et al., 1995). Therapists also provided the number of sessions each client had attended in therapy and their stage in therapy. The latter was determined by a subjective therapist rating scale (see Black, Curran, & Dyer, 2013) that assessed whether each participant was at the "start", "middle", and "end" stages of treatment based on therapeutic progress.

Procedure

A participant information sheet was given to all clients engaged in therapy in the targeted services. Volunteers interested in taking part in the study contacted the research team and an independent meeting was arranged between a researcher and the client in order to complete the study questionnaires. Participants were administered all the measures in one session. After completion, the researcher approached the client's therapist who provided additional clinical information.

Results

Clinical characteristics

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

All participants had experienced three or more traumatic events, with 63% of participants reported experiencing 6 or more in their life ($M = 5.16$, $S.D = 1.33$). All participants also met DSM-IV criteria for chronic PTSD (i.e., > 3 months). The most common traumatic experiences were: 1) “Troubles”- related trauma (e.g., bombing, torture; 93%); 2) non-sexual assault from stranger (65%); 3) serious accident (51%); 4) non-sexual assault from family member (46%); 5) imprisonment (44%); 6) military combat (44%); and 7) sexual contact as a minor (28%) . Based on the similarities between these sample characteristics and other studies conducted in this population (e.g., Dorahy et al., 2009; Dyer et al., 2009), as well as the frequencies of Complex PTSD reported in previous research completed within these trauma services (i.e., 95% clinical levels of Complex PTSD; Dorahy et al. 2013), the results suggest that the sample is representative of a Northern Ireland chronic, complex trauma cohort. Clients had been attending for a median average of 27 therapeutic sessions (range 6 – 104 sessions) at the time of alliance measurement. In terms of stage of therapy, 2 participants (3%) were rated as at the “start” of therapy, 32 participants (55%) in the “middle” stage of therapy, and 24 (41%) at the “end” stage of therapy by their clinician.

The sample means and standard deviations for the attachment subscales, coping strategies, and alexithymia are in Table 1.

Insert Table 2 about here

Analyses

Data from all 59 participants were included in correlational/regression analyses of the dependent variables of adaptive coping, maladaptive coping, and therapeutic alliance. Due to the limited sample size and large number of clinical factors measured, a focused set of

predictor variables were selected to test the study hypotheses. Potential psychological variables (e.g., attachment dimensions) as well as specific clinical factors (i.e., number of traumatic events) were initially correlated with the criterion variables (see Table 2 and Table 3). Those variables that exhibited 1) a correlation coefficient of >0.25 with the criterion variable; and 2) the relationship was significant ($p < 0.05$) were selected for subsequent backwards stepwise regression analyses.

Attachment, alexithymia and coping strategies

Initial correlations between the two overarching coping strategy scales and the factors of attachment dimensions, alexithymia, number of therapy sessions, and number of traumatic events are in Table 2. Use of adaptive coping strategies had no significant correlates aside from the ASQ Confidence subscale ($r = .31$; $n = 59$; $p = .016$). Maladaptive coping strategies, however, were significantly correlated with alexithymia ($r = .26$; $n = 59$; $p = .048$), Pre-occupation with relationships ($r = .27$; $n = 59$; $p = .038$), and Need for approval ($r = .44$; $n = 59$; $p < .0005$).

Insert Table 2 about here

Two backward stepwise regressions were performed to gauge the unique contribution of each significant correlate of the adaptive/maladaptive coping strategy dependent variables and provide the most parsimonious model. For adaptive coping, only ASQ Confidence was a significant correlate and was inputted as the sole predictor in the model ($F_{(1, 57)} = 6.14$; $p = .016$, $R^2 = .097$), accounting for 10% of variance in adaptive coping ($\beta = .31$; $p = .016$). For maladaptive coping, alexithymia, ASQ Pre-occupation with relationships, and ASQ Need for approval were included as predictor variables in a backwards stepwise regression. Only ASQ

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

Need for approval remained in the final model as a significant predictor of maladaptive coping ($\beta = .45$; $p < .0005$), explaining 20% of variance in this criterion variable ($F_{(1, 56)} = 14$; $p < .0005$, $R^2 = .2$). Alexithymia and ASQ Pre-occupation with relationships were removed from the regression via the stepwise process.

Client characteristics and the therapeutic alliance

Table 3 contains the correlations between the client characteristics (i.e., attachment dimensions, alexithymia, coping strategies, number of traumatic events) and the therapeutic alliance

Insert Table 3 about here

A number of coping styles were correlated with the therapeutic alliance, including “Acceptance” ($r = .37$; $n = 59$; $p = .004$), “Emotional support” ($r = .46$; $n = 59$; $p < .0005$), “Instrumental support” ($r = .5$; $n = 59$; $p < .0005$), “Planning” ($r = .27$; $n = 59$; $p = .003$), “Positive reframing” ($r = .27$; $n = 59$; $p = .037$) and “Venting” ($r = .38$; $n = 59$; $p = .003$). No significant relationships were found between the therapeutic alliance and the variables of number of traumatic events alexithymia, and client attachment dimensions.

Backward stepwise regression was again performed to gauge the unique contribution of each of these variables. Coping styles of “Acceptance”, “Emotional support”, “Instrumental support”, “Planning”, “Positive reframing”, and “Venting” were initially inputted as dependent variables. As a result of the stepwise process, “Instrumental support”, “Planning”, and “Positive reframing” were excluded from the analysis. The final model is in

Table 4 and was found to be significant ($F_{(3, 55)} = 8.64$; $p < 0.0005$, $R^2 = 0.32$), accounting for 32% of the variance in client-rated therapeutic alliance. The coping strategies of “Acceptance” ($\beta = .25$; $p = .032$) and “Emotional support” ($\beta = .31$; $p = .017$) were significant predictors of the therapeutic alliance with “Venting” ($\beta = .22$; $p = .075$) approaching significance.

Insert Table 4 about here

Discussion

The aim of the current study was to explore how client psychological factors, specifically attachment style and alexithymia related to the type of coping strategies and quality of therapeutic alliance within a chronic, complex trauma population. The most notable finding was that current client coping strategies of “Acceptance” and “Emotional support” were the biggest predictors of the quality of the therapeutic alliance, over and above engrained psychological-characterological factors such as attachment style and alexithymia, which emerged as non-significant correlates of the alliance. Moreover, client “need for approval”, which represents a tendency towards a preoccupied adult attachment style, was significantly associated with engagement in maladaptive coping strategies (i.e., self-distraction, denial, substance use, behavioural disengagement, venting, and self-blame).

Previous research has mainly investigated the association between client characteristics and the quality of alliance in therapies of short duration (Hersoug, et al., 2009). Furthermore, most investigations that explored similar client characteristic – alliance

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

relationships to the current study measured the alliance only in the early stages of therapy (Dinger, Strack, Leichsenring, & Schauenburg, 2007; Hersoug et al., 2009). Somewhat uniquely, the present study obtained alliance ratings from participants engaged in long-term therapy – primarily in middle to end stages of completion – and found that current coping strategies were the most salient correlates of the alliance. Such findings tentatively suggest that different client factors may be important in affecting the therapeutic alliance at different stages of therapy.

In terms of specific coping strategies, “Acceptance”, “Emotional support”, “Instrumental support”, “Planning”, “Positive reframing”, and “Venting” yielded significant positive correlations with the therapeutic alliance. However, in the final regression, “Acceptance”, “Emotional support”, and “Venting” presented as the three most prominent client characteristics, accounting for 32% of the variance in alliance scores. It is, perhaps, unsurprising that individuals who employ “Emotional Support” and “Venting” are more likely to have an effective therapeutic relationship as these strategies refer to the tendency to seek/use moral, emotional support from others and to express/discharge feelings, both of which are supported in therapy (Carver, 1997). More interestingly from a therapeutic stance, “Acceptance” was also a significant predictor. This strategy is defined as an individual accepting that a significant, stressful event has happened as well as being able to tolerate its consequences and implications (Carver, 1997). Potential explanations for these findings are that the presence of an “Acceptance” coping strategy means the client is more likely to have accepted the traumatic experience and its repercussions, thus reflecting a more flexible cognitive style. It has been repeatedly shown that such psychological flexibility is predictive of therapeutic outcome (Woidnick, Morrison, & Twohig, 2014). On the other hand, it must be acknowledged that the directionality of coping – alliance relationship cannot be definitively stated as coping strategies influencing later alliance development due to the limitations of the

cross-sectional methodology employed in the current study. For example, it cannot be discounted that clients who have a positive therapeutic alliance actually develop these coping strategies as a result receiving therapy. Therapists are more likely to support the use of such emotion-focused strategies as a means to bringing about therapeutic change.

The role of the preoccupied attachment factors of “Need for Approval” and “Preoccupation with Relationships” in maladaptive coping strategies also fits with the existing literature. Research has indicated that a preoccupied attachment style is a significant risk factor for increased PTSD symptomatology and that individuals with this attachment style are less likely to employ therapeutic strategies or rational coping strategies in emotionally challenging situations (O’Connor & Elklit, 2008; Muller, Sicoli, & Lemieux, 2000). Berry, Barrowclough, and Wearden (2007) state that such individuals would benefit more in therapy by focusing less on their emotional distress and more on reduction of unhelpful coping choices, which is concordant with the present findings. It would be expected that such an association would extend to a negative relationship between preoccupied attachment scales and adaptive coping strategies; however, the lack of relationship between adaptive coping and psychopathology predictors has been found in a number of previous studies (e.g., Aldao & Nolen-Hoeksema, 2012). In the current study, only the “Confidence” scale was related to adaptive coping, which suggest that a healthy, secure attachment may be a foundation for the development of helpful coping methods. However, as with the coping – alliance relationship, an alternative interpretation could be that as helpful coping strategies develop, clients may retrospectively perceive themselves as more securely attached.

These key findings are novel as to date there has been no research that has explored the interrelationships between client characteristics, coping strategies and the therapeutic relationship. Theories on trauma have suggested that the experience of traumatic events can

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

fragment an individual's conceptual system and core inner representations (Goldenberg & Matheson, 2005), fundamentally influencing coping strategies. The fact that adoption of more adaptive coping strategies is possible in a chronic, complex trauma group and that this increases the likelihood of an effective alliance is hopeful for prognosis within this population. Moreover, in terms of the local context, it is also positive that a predominantly male sample from the prolonged sectarian conflict area of Northern Ireland – which has recognized high levels of ingrained psychopathology relative to other nations (see Bunting, Murphy, O'Neill, & Ferry, 2011) – can develop working alliances. This is further supported upon examination of the high mean alliance score of the current sample (i.e., 217.14), which was higher than published mean alliance scores in other less severe clinical populations (e.g., 205.5; Cook & Doyle, 2002).

The experience of living with multiple traumas was very evident in this population and consistent with previous research (Dorahy et al., 2009). However number of traumatic experiences did not have any significant relationship to the therapeutic alliance. This finding is encouraging as it would suggest that experiencing multiple traumata does not act as a barrier to therapy per se. Alexithymia and attachment style were also not related to the therapeutic alliance, which may be an indication that these variables are salient in the initial stages of therapy and not as relevant to alliance development as client coping strategies during the middle to latter stages of therapy. Such interpretations should be made with caution but are consistent with previous research. Holvey (1996) found that the negative impact of alexithymia on the therapeutic alliance was restricted to the early stages of therapy. Moreover, Hersoug et al. (2009) reported that client interpersonal difficulties indicative of a cold, detached, dismissive attachment style only had a detrimental effect on the early development of the alliance, but that this negative impact substantially reduced over time. Other authors such as Schore (2001) would argue that as therapy progresses, it may induce

subtle changes in neurobiological mechanisms of affect regulation, which may foster a positive alliance and a more secure form of attachment.

There are some important limitations in the present study. The overall sample size was relatively small and larger scale studies are required to corroborate current findings. The high proportion of males within the sample alongside the high prevalence of “Troubles”-related trauma, limits the generalisability of findings to other trauma and clinical populations. Moreover, although all participants met diagnostic criteria for chronic PTSD, the definition of the sample as being a “chronic, complex trauma” cohort was largely inferred based on the multiple traumatic experiences recorded and the fact that previous studies in these treatment services have found extremely high levels of Complex PTSD in this type of trauma sample. Nevertheless, it has been reported that complex traumatic experiences in childhood and adulthood make different contributions to later Complex PTSD (Cloitre et al., 2009). Consequently, the inclusion of a more robust standardised assessment of both child and adult trauma history as well as Complex PTSD symptomatology would improve the rigour of such research.

A positive aspect of the study design was that participants were recruited at any stage in therapy and not restricted to the early stages of intervention. However, the opportunity sampling method and lack of control meant the eventual sample was skewed to middle – end stages of therapy and possibly affected by selection bias. Despite this potential bias, the open stage of therapy criteria provided some important and useful findings concerning the therapeutic alliance and its assessment. Data for the therapeutic alliance was also gathered from one time point, whereas it is accepted that ratings of alliance change over time and that longitudinal, repeated measures of alliance should be implemented to increase the validity of findings (Kramer, de Roten, Beretta, Michel, & Despland, 2008). Yet, such a design is challenging both ethically and pragmatically.

CLIENT FACTORS, THERAPEUTIC ALLIANCE, AND TRAUMA

The results of this study have a number of important clinical implications. Trauma therapists can be encouraged by the findings that although clients may present with complex relational needs, they are not insurmountable barriers in therapy and useful therapeutic alliances can develop over time. This interpretation emphasizes the importance of the client-therapist dynamic in psychotherapy, which is particularly salient considering the quality of the alliance is also predictive of eventual therapeutic outcome (Martin et al., 2000).

Client characteristics were found to account for around a third of the variance in therapeutic alliance. However, it is likely that some of the alliance variance may further be explained by therapist characteristics and therapeutic modality. Ackerman and Hilsenroth (2003) found both therapist personal attributes as well as therapist techniques to contribute positively to the alliance. Future studies should aim to expand on the current findings and assess both client and therapist factors across stages of therapy to comprehensively map out the varying influences on the alliance across the therapeutic journey.

In conclusion, the present study found that preoccupied attachment factors (e.g., “Need for Approval”, “Preoccupation with Relationships”) were related to use of maladaptive coping strategies in a chronic, complex trauma sample, whereas the secure attachment factor (e.g., “Confidence”) was related to use of adaptive coping strategies. More significantly, only the coping strategies of “Acceptance” and “Instrumental support” were associated with a positive therapeutic alliance. Encouragingly, traditionally hypothesised barriers to the alliance such as frequency of traumatic experiences, insecure attachment style, and alexithymia were not found to be related the therapeutic alliance.

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Table 1. Sample means and standard deviations for therapeutic alliance, alexithymia, coping strategies and attachment scales

<i>Variable</i>	<i>Mean</i>	<i>SD</i>
Therapeutic Alliance	217.14	22.82
Alexithymia	66.55	13.29
Coping Strategies		
Acceptance	6.02	1.65
Active coping	5.92	1.79
Emotional support	5.58	1.92
Instrumental support	5.92	1.77
Planning	5.76	1.76
Positive reframing	4.64	1.93
Humour	3.80	2.04
Religion	3.95	2.26
Behavioural disengagement	3.92	1.75
Denial	4.00	1.72
Self distraction	5.24	1.76
Self blame	6.58	1.55
Substance use	3.93	2.22
Venting	5.14	1.70
Attachment Dimensions		
Confidence	28.50	5.44
Discomfort with closeness	44.63	7.02
Relationships as secondary	27.08	4.02
Preoccupation with relationships	30.15	4.33
Need for approval	28.15	5.45

Table 2. Correlations between client clinical/psychological characteristics and adaptive/maladaptive coping

<i>Independent variables</i>	<i>Adaptive Coping</i>	<i>Maladaptive Coping</i>
Number of traumatic events	-.06	-.01
Number of therapy sessions	-.04	.03
Alexithymia	-.2	.26*
Attachment Dimensions		
Confidence	.31*	-.19
Discomfort with closeness	-.05	.24
Relationships as secondary	.02	-.24
Preoccupation with relationships	.07	.27*
Need for approval	.06	.44**

*p < .05.**p < .001

Table 3. Correlations between client clinical/psychological characteristics and the
therapeutic alliance

<i>Independent variables</i>	<i>Therapeutic Alliance</i>
Number of traumatic events	-.19
Number of therapy sessions	-.10
Alexithymia	-.17
Coping Strategies	
Acceptance	.37**
Active coping	.24
Emotional support	.46**
Instrumental support	.5**
Planning	.38**
Positive reframing	.27*
Religion	.04
Behavioural disengagement	-.08
Denial	.06
Self distraction	.05
Self blame	.2
Substance use	-.06
Venting	.38**
Attachment Dimensions	
Confidence	.11
Discomfort with closeness	.12
Relationships as secondary	.11
Preoccupation with relationships	.09
Need for approval	-.09

*p < .05. **p < .001

Table 4. Summary of hierarchical regression for coping strategies predicting client-rated therapeutic alliance

	B	SE B	β	R^2	Sig. (<i>p</i>)
				0.32	< 0.0005
Acceptance	3.53	1.6	0.25		0.032
Emotional Support	3.64	1.49	0.31		0.017
Venting	2.98	1.64	0.22		0.075